Program Approval #: _____

STATE OF MAINE
Department of Education

Application for CNA Competency Testing

ALL APPLICATIONS FOR TESTING MUST BE ACCOMPANIED BY
A SATISFACTORILY COMPLETED **SKILLS CHECKLIST**

INFORMATION MUST BE TYPED

Sponsored by: _____ _____
(Name of Educational Delivery System) **(Person administratively responsible for program, e.g. Voc. Director, Adult Ed. Director, Nursing Dept. Chair)**

Signature of Administrator of Program: _____

Telephone Number for Administrator: _____

Administrator's Email: _____

Primary Instructor's Name: _____

Instructor's Signature: _____

Total Classroom/Laboratory Hours: _____/_____

Total Correlated Supervised Clinical Practice Hours: _____

Program Beginning Date: _____ Program Ending Date: _____

Number of Students Taking Test: _____ Date Test Will Be Given: _____

Indicate Complete Name and Address as to Where Tests Are to Be Mailed:

A testing fee of $20.00 per student will be charged. Fees for testing must accompany the application. Please make checks payable to Treasurer, State of Maine.

PLEASE RETURN THIS FORM TWO WEEKS PRIOR TO EXAM DATE

Gail Mazzaro
Department of Education
23 State House Station
Augusta, ME 04333-0023
Telephone: (207) 624-6730 Fax: (207) 624-6731

Department of Education Use Only
Date Application Received: _____
Date Tests Sent: _____
Date Test Returned: _____

FOR OFFICE USE ONLY

Check # _____B.T. # _____ Date Received: _____ Amount: _____

List Name, Social Security Number, Date of Birth, and Address of Each Student

	Last Name	First Name	Middle Initial	Social Security Number	DOB	Mailing Address
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						

Please use additional sheet if necessary

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Check # _____B.T. # _____ Date Received: _____ Amount: _____